IN THE VERMONT SUPERIOR COURT
WASHINGTON COUNTY CIVIL DIVISION

JUVENILE # 1 (N.B.), Plaintiff,	) Case No. 192-4-19 Wncv
-against-	) Montpelier, Vermont
KENNETH SCHATZ, Defendant.	) April 16, 2019) 9:04 AM

TRANSCRIPT OF REQUEST FOR EMERGENCY INJUNCTIVE RELIEF

BEFORE THE HONORABLE MARY MILES TEACHOUT,
SUPERIOR COURT JUDGE

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running into the staff or to the staff, and I don't see those as proportional. So standing aside would have been another option.

Once they chose to engage the restraint, I assume you're going to start asking me about my concerns about the restraint itself.

Q. Just one -- a few questions about the initiation of the restraint. Was it your understanding that there was an order authorizing that restraint?

A. Yes.

Q. When was that order issued?

A. Four-something. It was, I believe, well a half hour or more before when the restraint actually occurred.

Q. Okay, thank you. Actually, let's move to the next segment, which is when they engage in the restraint on juvenile number 1. What did you see during that segment that gave you cause for concern?

A. It was ugly. It used a methodology, a physical methodology, that I have never seen used with any population, certainly no child or adolescent population.

Again, it was a difficult situation because of where they were, which might have again played into the calculus on whether or not to initiate a restraint at that point. Again using a risk-reduction model, there are no good alternatives in that circumstance, but there were probably other

alternatives that might have been safer.

The things that stand out about the actual restraint was the -- the -- the practice at Woodside, as I understand it, to turn the arm of the individual being restrained up and back. And I have a yoga practice, and this is not an easy position to -- it defies the typical range of motion associated with the shoulder, and --

Q. Is there a term for that?

A. Hyperextension.

Q. Okay, go ahead, continue to describe your concerns.

A. So they have juvenile 1 with one arm in this position with pressure being applied upwards. I think because typically, as I understand it, Woodside would have the other arm in the same situation, and you see that later when they move to the soothing room and they have both arms in that position. I think --

Q. Can I just interrupt you, Dr. Bellonci? We need a record -- a --

A. A physical description of --

Q. Yes.

A. -- what I'm doing with my body?

Q. So your description is wonderful for the folks in the courtroom, but can you -- when you -- can you describe hyperextension and indicate when you're exhibiting that, what is it you're doing with your words?

A. I will -- I will do my best to describe what I'm gesticulating. So it's a grabbing of the arm and twisting it behind and above the individual's back with a staff person typically on either arm -- I think because of the location on the bed, the other arm was not put into that position but was instead just folded behind juvenile 1.

And then another practice which I have seen only at Woodside is grabbing the legs, crossing them, and then applying pressure of the legs against the body. Again, not an ideal situation, but the staff person then had both -- had climbed up onto the bed and was using his knee against juvenile 1's neck. You never want to apply any pressure on the neck or the back because the deaths that occur in restraints are a direct result of asphyxiation.

When we met with juvenile 1 yesterday, he said he could not breathe, and you could see in the video tape that he stops speaking, and nobody addressed that, which was concerning, because he was pretty verbal up until that point. His face was turned away, so were he to become cyanotic, meaning that he was dying, he was turning blue; nobody could have seen his face.

The staff person that had -- the larger guy who was at the door, was busy clearing out the room. Nobody was observing his face for any sign of anoxia. You can hear that when they do decide to move him, he starts coughing, and he

says I couldn't speak because I couldn't breathe. And there doesn't seem to be any immediate concern about that by staff and that wasn't even addressed in kind of when they were talking about what happened and were there any injuries. That's concerning to me, because it happens again when they move him to the soothing room.

Q. So from a medical standpoint, what is a common measure with which you are familiar to address this issue of possible inability to breathe during prone restraints?

A. There is some agencies that use a device called a pulse oximeter, which is a medical device that you can put on the finger and it reads what, in real-time, the blood oxygenation is. But a low-tech method is just to ensure that somebody's observing the face because it's usually the lips that turn blue first.

Q. Okay, and what is the role of a -- in your experience, what is the role of a clinician during a restraint?

A. Not to be directly involved in the restraint. I'd say once the restraint is initiated, it's probably too late for the clinician to have a role.

Q. Okay. Could the clinician be a person who was observing for breathing?

A. Yes.

Q. Okay. All right, so on the bed, how many arms were

in hyperextension at that point?

A. I believe it was just the right arm.

Q. Okay. And would you describe what they were doing with his legs as hyperextension at that point or how would you describe that?

A. I'm not sure I would call it hyperextension, but it looked very painful. And again, I've never seen that particular approach to restraining legs, so they were crossed and then they were bent backwards to the point where his heels were making contact with his butt.

Q. Okay. So let's move to the next segment that you saw on the video which is when they escort him from the room that he was in to the seclusion room.

A. Right.

Q. The question is, did you see -- did anything that you saw during that segment of the video concern you, and why?

A. Yes. Escorts are another big area of concern. It's the most risky for staff to sustain injuries, and you could see why in that video. It's very difficult to move someone who is agitated. And they made the decision that, for whatever reason, they wanted to move him into that isolation room. The room he was in was already being used in isolation, from my perspective, because it was locked. So they had already cleared out, so I don't know what the immediate threat was to warrant the risk associated with an escort.

The escort itself was really hard to watch. The -- they have a method where they have an arm secured, and then they grab each other's arm underneath his chest. But in this case, it appeared that their arms had slipped up to his neck, and particularly where they were trying to squeeze through the narrow doorway, it looked like he was being choked, and he was making sounds that sounded like he was being choked.

They then escort him the rest of the way through the hall and move him into the room, and you can hear when they put him down onto the floor. It sounds like he's gasping for breath, having been choked, and he's coughing at that point.

Q. Okay, so let's move to the events in the seclusion room.

A. Okay.

Q. Similar question. What did you see -- did you see things that caused concern, and what were your concerns?

A. At that point, the restraint appeared similar to what I had seen in other complaints -- very, very consistent. That what we saw, I think, at that point was a -- representative of the restraint method used at Woodside. So again, both arms -- I'll describe it rather than show it. Both arms in this movement bent over, you know, being pulled back assertively by the staff, being held up in hyperextension. A staff person on his legs, with the legs crossed with pressure being applied, folding those legs, the crossed legs, back to the point where

way so that they can see that there is a way out for them, and that by ultimately complying with the expectations, better things will happen for them.

And one of the concerns is that he's not feeling like the rewards are close enough in proximity to the behavior that he's supposed to display. And that's problematic because he'll feel like he has done what was asked of him, and he articulated this with us yesterday. But the reward is too distant.

So for instance, he said that he was complying with taking his medication and he feels like that's been helping. And he's shown other positive indicators of compliance, and so he was going to earn the ability to go to class outside of the North Unit, which is largely self-contained, but it was going to be the next day.

And if indeed, he is as developmentally delayed as suggested, you can't have it be that far. If you think about a seven or eight-year-old, it's not enough to say you're going to get your reward tomorrow. You've got to have it much more proximal to whatever it is that you're asking of him.

Q. So I just want to end with a final question regarding the risk to juveniles at Woodside should these practices not be enjoined; can you speak to that generally?

A. I worry for his immediate safety and I worry about his long-term -- the long-term impacts of this experience.